SOUTH KINGSTOWN SCHOOL DEPARTMENT
307 Curtis Corner
Wakefield, RI 02879
(401) 360-1300

REGISTRATION INSTRUCTIONS

STEP 1: **Complete the online pre-registration process:**

Prior to your registration appointment, please complete the online pre-registration process. Please visit our website www.skschools.net and click on the 'Enrolling Students' tab under 'Quick Links'. On the Registration Page, the pre-registration link will be found under Step 1: SKSD Pre-Registration. This process will create your Family Access account in Skyward.

STEP 2: **Download, print, and complete the registration packet. Included in the registration packet are the following forms:**

- Home Language Survey Form (Required by the Rhode Island Department of Education)
- Request for Transportation Form
- Release of Information
- Residency Affidavit
- McKinney Vento Student Residency Form
- Student Health History Form

STEP 3: Gather Required Documentation:

In addition to the registration packet, the following documentation must be provided at the time of your registration appointment:

- Birth Certificate (Official Copy Only) or Passport or Military ID (Child must be 5 yrs old on or before September 1 to enter Kindergarten)
- Photo Identification of Parent/Guardian
- Court Documentation (Legal documentation proving custody or guardianship, if applicable)
- Residency Evidence - A true copy of one (1) piece of current residency evidence from Column A and one (1) piece from Column B

Column A	Column B
Copy of Mortgage Statement	Copy of Cable Bill
Copy of Property Tax Bill	Copy of Electric Bill
Copy of fully executed Lease; Rental Agreement, Letter from Landlord	Other

- Pediatrician/State Physical Form with Immunizations - All forms must be signed by your child's doctor and must contain the most recent immunizations and up to date physical information (dated within one year). Kindergarten-age children must have a lead screening and a vision screening before they can be entered into school.)
- Any Additional Documentation - Please bring any information regarding services your child may receive, ie. Individual Education Plan, 504 Plans, Response to Intervention Services, or English Language Learner Services)

STEP 4: Schedule your registration appointment: **Click Here**

Grade Level	Contact	Location	Office Hours
Grades PreK through 12	Kristen Gleason (401) 360-1325 kgleason@sksd-ri.net	SKSD Central Office 307 Curtis Corner Rd Wakefield, RI 02879	9:00 am - 3:00 pm

Please contact the Registrar's Office if you would like a copy of the printed packet or if you have any questions.

State of Rhode Island and Providence Plantations
DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Shepard Building
255 Westminster Street
Providence, Rhode Island 02903-3400

Angélica Infante-Green
Commissioner

Home Language Survey (HLS)

Dear Parent or Guardian,

The information requested on this form is necessary for the most appropriate school placement of your child, and will not be used for any other purposes[1]*.*

Thank you for your collaboration.

To be completed by Parent or Guardian

Student Name:	
First *Middle* *Last*	
Date of Birth:	**Place of Birth**[2]**:**
	_____
Month *Day* *Year*	

Parent or Guardian Relationship to student:
☐ *Mother* ☐ *Father* ☐ *Other* _____

Home Language Code:

Language Background

(Please check all that apply)

1. What is the primary language used in the home, regardless of the language spoken by the student?	☐ English	☐ Other	_____ *Specify*
2. What is the language most often spoken by the student?	☐ English	☐ Other	_____ *Specify*
3. What is the language that the student first acquired?	☐ English	☐ Other	_____ *Specify*
4. What language(s) does your child understand?	☐ English	☐ Other	_____ *Specify*
5. What language(s) does your child speak?	☐ English	☐ Other	_____ *Specify* ☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other	_____ *Specify* ☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other	_____ *Specify* ☐ Does not write

[1] *Required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f))*

[2] *Families are not required to provide the place of birth, but providing the information can help LEAs to better prepare to be culturally responsive.*

Last Updated: 4/30/2020

The R.I. Board of Education does not discriminate on the basis of age, sex, sexual orientation, gender identity/expression, race, color, religion, national origin, or disability.

Family Interview – Educational History

1. **Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.**

Yes* ☐ No ☐ Not sure ☐ *If yes, please explain:_____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

2a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes*

If referred for an evaluation, has your child been identified? ☐ No ☐ Yes

*If referred for an evaluation, and identified has your child ever received any special education services in the past?

☐ No ☐ Yes – Type of services received: _____

2b. Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

2c. Does your child have an Individualized Education Program (IEP), or 504 plan? ☐ No ☐ Yes

3. In which language do you prefer to receive oral communications from the school or district? ☐ English ☐ Other _____ *Specify*

4. In which language do you prefer to receive written communications from the school or district? ☐ English ☐ Other _____ *Specify*

5. Indicate date first enrolled in ANY U.S. school _____ **(mm/dd/yyyy)**

Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

_____

_____

_____ Month: Day: Year:

Signature of Parent or Guardian ***Date***

_____

Print Parent/Guardian Name

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLS

Name: _____ Position: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLS AND CONDUCTING INDIVIDUAL INTERVIEW

Name: _____ Position: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____

Oral Interview Necessary: ☐ YES ☐ NO **Date of Individual Interview:** _____ *Month Day Year*

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING THE LANGUAGE SCREENING ASSESSMENT

Name: _____ Position: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____

NAME/POSITION OF QUALIFIED PERSONNEL REPORTING THE LANGUAGE SCREENING SCORES

Name: _____ Position: _____

Date of Screener: _____ *Month Day Year*

Name of the Language Screening Assessment: _____

Score achieved: _____

Proficiency Level Achieved: Entering 1 ☐ / Beginning 2 ☐ / Developing 3 ☐ / Expanding 4 ☐ / Bridging 5 ☐ / Reaching 6 ☐

FOR STUDENTS WITH AN IEP OR 504 PLAN, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED:

SOUTH KINGSTOWN SCHOOL DEPARTMENT
307 Curtis Corner Road
Wakefield, RI 02879
(401) 360-1300

RELEASE OF INFORMATION

Student:_____ Grade: _____ DOB: _____

☐ **Matunuck Elementary School**
380 Matunuck Beach Rd
Wakefield, RI 02879
P (401) 360-1234
F (401) 360-1235

☐ **Peace Dale Elementary School**
109 Kersey Rd
Peace Dale, RI 02879
P (401) 360-1600
F (401) 360-1601

☐ **Wakefield Elementary**
101 High St
Wakefield, RI 02879
P (401) 360-1400
F (401) 360-1401

☐ **West Kingston Elementary School**
3119 Ministerial Rd
West Kingston, RI 02892
P (401) 360-1130
F (401) 360-1131

☐ **Broad Rock Middle School**
351 Broad Rock Rd
Wakefield, RI 02879
P (401) 360-1800
F (401) 360-1801

☐ **Curtis Corner Middle School**
301 Curtis Corner Rd
Peace Dale, RI 02879
P (401) 360-1333
F (401) 360-1334

☐ **South Kingstown High School**
215 Columbia St
Wakefield, RI 02879
P (401) 360-1000
F (401) 360-1464

☐ **South Kingstown School Dept**
307 Curtis Corner Rd
Wakefield, RI 02879
P (401) 360-1300
F (401) 360-1330

This Release of Information is valid from ____ /____ /____ to ____ /____ /____

I hereby authorize the South Kingstown School Department to:

Choose only one on the left:

❑ Release to AND/OR ❑ Exchange Verbal Information
❑ Obtain from

PERSON/AGENCY: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

Records to be released or disclosed*:

❑ Cumulative School Records
❑ School Profile (High School Only)
❑ Health and Immunization Records
❑ RIDE Accountability Assessments
❑ 504 Plan, including testing/outside recommendations
❑ Personal Literacy Plan (PLP), including testing results
❑ Personal Math Plan (PMP), including testing results
❑ Personal Behavior Plan, including testing results
❑ Psychological Evaluation
❑ Educational Evaluation
❑ Psychiatric Evaluation
❑ Speech/ Language Evaluation
❑ Rating Scales
❑ RI Documentation for Free/Reduced Lunch Program
❑ Other: _____

The purpose of release/disclosure is:

_____

_____

_____

Medical/ Health information is protected under R.I. Law 78H-7522. Information released with this authorization will not be given, sold, transferred, or in any way released to any other person not specified on the release form. The consent for release or transfer of information may be withdrawn at any future time.

Signature of Parent/Guardian: _____ Date: ____/____/____

*Parent authorization is not required to transfer educational records to another school district.

OCEAN STATE TRANSIT
45 FAIRGROUNDS ROAD
WEST KINGSTON, RI 02892
(401)284-3920 FAX (401)284-3929

Entity Code
103 Wakefield
107 Peace Dale
108 SKHS
110 CCMS
112 West Kingston
113 Matunuck
114 BRMS

Student Name: _____ School: _____ Grade: _____ ID: _____

Home Address: _____ Home Phone: _____

Additional students in the family:

Student Name: _____ School: _____ Grade: _____ ID: _____

Student Name: _____ School: _____ Grade: _____ ID: _____

Student Name: _____ School: _____ Grade: _____ ID: _____

Please check below:

____ New Student

____ AM Transportation Needed Only

____ PM Transportation Needed Only

____ Both AM & PM Transportation Needed

The South Kingstown School Department will transport your child to or from any bus stop located within the boundaries of the school your child attends. The only requirement is that your child is picked up at the same location and transported to the same location every day.

____ **Pick-up at Daycare Provider/Alternate Address:**

_____ Address

_____ Contact Name

_____ Contact Number

____ **Drop-off at Daycare Provider/Alternate Address**

_____ Address

_____ Contact Name

_____ Contact Number

____ Student Exited

____ Change of address (Previous Address: _____)

Transportation Information page can be found at: https://www.skschools.net/parents/bus_information

(For Ocean State Transit use only)

Allow three days for transportation to start.

Bus Number:_____ Stop Location: _____ Pick-Up Time: _____Drop-Off Time: _____

SOUTH KINGSTOWN SCHOOL DEPARTMENT
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RESIDENCY AFFIDAVIT

CAUTION: Read this statement carefully before signing it. This document requires you to provide information which, if not true, could make you responsible for the payment of tuition for your child to attend the South Kingstown Schools.
All lines must be completed or checked off as directed.

I, _____, upon oath do hereby swear and say:
(parent/guardian name)

1. _____, whose birthdate is _____, herein
(child's legal name) *(month/day/year)*
referred to as the child, will reside permanently with me at my residence during the **2023-2024** school year at _____
_____, in the South Kingstown, Rhode Island Public School District.
(street address)

2. ***(Check one only if you are not natural or adoptive parents of child):***
The child's parents:
_____are unknown; _____are not living; _____have abandoned the child; or, _____are unable to care for the child.

3. ***(Check one only if you are not natural or adoptive parents of child):***
I have assumed *(check one)* _____legal guardianship or _____parental responsibility as provided in Rhode Island General Law, Section 16-64-1, for the welfare and conduct of the child.

4. The child is not living in the South Kingstown School District for the sole purpose of attending the South Kingstown Schools**.**
_____True _____False

5. Submitted with this statement, if applicable, is a certified copy of a court order granting me legal guardianship or a statement from the child's parent(s) of inability to care for the child. **_____Applicable _____Not Applicable**

6. I understand that only residents of the Town of South Kingstown who are otherwise eligible are entitled to be educated by the Town of South Kingstown without charge**. _____*Please Initial***

If any of the statements in Sections 1 through 6 above ceases to be true, I shall notify the South Kingstown School Department in writing immediately. If the child is permitted to remain in the South Kingstown School System, I will be responsible for payment of tuition for the child at the prevailing district rate on a pro-rated basis from the date any statement in Sections 1 through 6 above ceases to be true. Such tuition shall become immediately due and payable.

_____ _____
(Parent/Guardian printed name) (Parent/Guardian signature)

_____ _____
(Street address) (City, State, Zip)

_____
(Relationship or designation to child)

Subscribed and sworn to in my presence this _____day of _____, 20_____

_____ _____
Notary Public Signature Notary Commission Expires

SOUTH KINGSTOWN SCHOOL DEPARTMENT
307 Curtis Corner
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MCKINNEY VENTO STUDENT RESIDENCY FORM

By completing this questionnaire, you help the school district comply with the McKinney-Vento Homeless Assistance Act, as amended by Title IX, Part A of the Every Student Succeeds Act, Pub. L. No. 114-95. Your truthful and accurate answers help the district identify services the student may be eligible to receive.

School _____

Student's name _____

❑ Male ❑ Female Birth date (Month/Day/Year) _____ Age _____

Parent(s)/Legal guardian(s) name _____

Address _____

City/State/Zip _____

Phone number _____

1. Where is the student living now? (*Check one box*)

- ❑ In an emergency or transitional shelter.
- ❑ In a motel or hotel or abandoned at a hospital.
- ❑ In a car, park, abandoned building, or public space.
- ❑ In a trailer park, bus or train station, or camping ground.
- ❑ With more than one family in a house or apartment.
- ❑ With friends or family members (other than parent/guardian).
- ❑ In a permanent residence that is fixed, regular, and adequate.

If you checked the last box marked "in a permanent residence that is fixed, regular, and adequate," you do not have to complete the remainder of this form. Please sign below and return a copy of this form either by mail to *South Kingstown School Department, 307 Curtis Corner Road, Wakefield, RI 02879* or by fax at *(401) 360-1330* or by email to *Karen Buetens, Family and Community Engagement Coordinator, at kbuetens@sksd-ri.net.*

2. Does the living arrangement checked in Question No. 1 result from a loss of housing or economic hardship?

❑ yes ❑ no ❑ unsure

The South Kingstown School Department does not discriminate on the basis of
age, sex, race, religion, national origin, color or disability in accordance with applicable laws and regulations.

3. **The student lives with:**
    - ❑ One (1) parent.
    - ❑ Both (2) parents.
    - ❑ A parent and another adult.
    - ❑ A relative, friend, or other adult.
    - ❑ Alone with no adults.
    - ❑ An adult who is not the parent nor the legal guardian.

4. **Name student's siblings, if any.**

_____

_____

_____

Parent/legal
guardian's signature _____ Date _____

Please return a copy of this form either by mail to *South Kingstown School Department, 307 Curtis Corner Road, Wakefield, RI 02879 or* by fax at *(401) 360-1330* or by email to *Karen Buetens, Family and Community Engagement Coordinator, at kbuetens@sksd-ri.net.*

FOR SCHOOL USE ONLY

❑ Student not covered under the McKinney-Vento Homeless Assistance Act.

❑ Student covered under the McKinney-Vento Homeless Assistance Act.

❑ Follow-up required.

Name and number of a contact person at the student's school who may know of the family's situation

_____ Date received _____

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age, sex, race, religion, national origin, color or disability in accordance with applicable laws and regulations.

SOUTH KINGSTOWN SCHOOL DEPARTMENT
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(401) 360-1300

STUDENT HEALTH HISTORY

Date:_____
Student's Name:_____Date of Birth:_____
Home Address:_____**Email Address:**_____
Home Phone_____Grade/Teacher_____
Name of physician or pediatrician_____Phone #_____

1.Check Any Current Health Conditions and describe
Asthma☐_____ Eczema☐_____ Bone or Joint Problems☐_____ Bladder/ GI/Bowel conditions☐_____
Diabetes☐_____ Scoliosis☐_____Anxiety☐_____Emotional Problems☐_____Bleeding Disorder☐_____
Seizures☐_____ Heart Conditions☐_____ Physical Disability☐_____ Other_____

2.Check Any Past Illnesses, Injuries, Conditions, Operations and describe
Strep Throat☐__Hives_☐__ Chicken Pox_☐_Pneumonia_☐_Lyme Disease☐Headaches☐Earaches or infections_☐___
Lead exposure and treatment____☐_____Developmental Milestones delayed (Walking, talking, etc.)-_____
Past influential event or trauma (Describe)_____Anxiety_☐___Injuries_____Nightmares_☐___Sleep
Difficulties_____Social/emotional difficulties (Describe)_____Surgery/Hospitalizations
yes,describe,date)_____Other_____Describe_____

3.Medications
Does your child presently take medication including inhalers **at home**? Yes_____ No_____
Please list here:_____
Is there any medication that needs to be taken **at school**? Yes_____ No_____
Please list here name of medication and time_____
MEDICATIONS IN SCHOOL must be administered by the nurse with specific written permission from the physician and parent (See South Kingstown Medication Policy).

4.Check any Allergies
Bee stings_____ Medications(Name of Med))_____ Food (Please list)_____
Requires Epipen_____ Requires Benadryl_____
Allergy to Environment_____ List allergens and treatments_____
_____
Any other allergies, reactions or treatments the school needs to know about_____
_____

5.Vision and Hearing
Does your child have any trouble hearing?_____ Tubes or hearing aides?_____
Does your child have difficulty seeing?_____ Wears glasses or contacts?_____

6. Dental Information R.I. State Law mandates that all students in Grades K-5 be examined by a dentist at least once a year and once during grades 6-10. Please indicate here the dentist that follows your child or the school dentist will see your child. ____
Dentist's name:_____ Address_____ Phone#_____
Last seen or date to be seen_____

7. Other
Any Dietary Restrictions?_____
Is your child able to fully participate in school activities?_____
Is your child being treated for anything right now?_____ If yes, explain_____
Please note any additional information in regards to your child_____
_____

** School Nurse will notify Chartwells Food Service of any Life Threatening Food allergies.
**Parents are responsible to notify bus driver and any after school programs about any health issues. Updated-2-2021
***Teachers and support staff will be able to view health concerns via Skyward program or may be informed as needed.

Parent Signature_____ **Date**_____